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Issue Date: 03 April 2006

Case Nos.: 2004-BLA-06763
2004-BLA-06764

In the Matter of:

TERRA MORROW, o/b/o and
Widow of PRESLEY MORROW
Claimant

v.

DRUMMOND COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest.

Appearances:

Samuel Maples, Esq.
For the Claimant.

Katie Loggins Vreeland, Esq.
For the Employer.

Before: **RALPH A. ROMANO**
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This proceeding arises from two claims for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act" or "the BLBA") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

[1] All applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

A formal hearing was held before me in Birmingham, Alabama on September 20, 2005. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations. Director's exhibits 1-48, Claimant's exhibits 1-4 and Employer's exhibits 1-2 were admitted into evidence at the hearing. (Tr. 7, 9, 10, 16).[2] The parties were granted the opportunity to submit post-hearing evidence. (Tr. 15-16). Claimant has submitted the following exhibits which are hereby admitted into evidence: Claimant's exhibit 5, by cover letter dated October 11, 2005, medical records from Walker Baptist Medical Center dating from November 14, 2002 to November 23, 2002; Claimant's exhibit 6, by cover letter dated November 3, 2005, the October 20, 2005 report of Dr. D. Gaziano; and Claimant's exhibit 7, by cover letter dated November 17, 2005, a report from Dr. Gaziano dated November 10, 2005. Both parties have also submitted post-hearing briefs. In its post-hearing brief, Employer argues that both claims are not timely and moves that they be dismissed. The record clearly establishes that the denial of benefits was appealed by the Claimant, and these matters are properly before me on requests for modification. Therefore, that motion is denied. The record is now closed.

Issues

The following issues are presented for resolution:

1. Whether the Miner had pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner was totally disabled;

4. Whether the Miner's disability or death was due to pneumoconiosis;

5. In the Miner's claim, whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. § 725.309; and

6. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denials pursuant to 20 C.F.R. § 725.310.

(Tr. 17, DX 44, 45).

[2] The following abbreviations are used herein: "DX" refers to the Director's Exhibits; and "CX" refers to Claimant's exhibits, "EX" refers to Employer's exhibits, and "Tr." refers to the transcript of the September 20, 2005 hearing.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

Findings of Fact and Conclusions of Law

Procedural Background

The Miner, Presley Morrow, filed his first application for benefits on December 5, 1983. It was denied in 1984. (DX 1). He filed his second application on June 13, 1991. An Order approving the withdrawal of the claim was issued on May 3, 1993, and therefore, that claim was deemed never to have been filed. *See 20 C.F.R. § 725.306*. The Miner filed his next application for benefits on January 4, 1996. (DX 1). It was finally denied on October 23, 1996. (DX 1). A claim filed on May 8, 2000 was denied on July 26, 2000, the determination being made that the miner had failed to establish the existence of pneumoconiosis arising out of coal mine employment or total disability due thereto. The instant claim was filed on April 29, 2002. (DX 3). The District Director, Office of Workers' Compensation Programs, issued a Proposed Order denying Benefits on January 22, 2003. (DX 19). The Miner died on November 23, 2002, and on May 6, 2003, his widow, the Claimant herein, filed an application for survivor's benefits. (DX 21). That claim was denied by the District Director on March 17, 2004. (DX 37). The District Director also issued a Proposed Decision and Order Denying Request for Modification on the Miner's claim, having deemed the application filed by the Miner's widow to be a request for modification of the denial in the Miner's claim as well. (DX 36). Counsel for Claimant wrote a letter dated April 14, 2004, which was received by the Department of Labor on April 19, 2004, requesting a hearing. (DX 38). As this was outside the thirty day period in which decisions can be appealed, the letter was deemed to be a request for modification. That request was denied by the District Director on July 19, 2004. (DX 40). Claimant filed a timely request for a hearing and these matters were subsequently referred to me for a formal hearing on March 14, 2005. A hearing was held before me on September 20, 2005. (DX 41, 44, 45).

Background

The Miner was born on June 29, 1929 and he died on November 23, 2002. (DX 26). Mrs. Morrow was married to the Miner on January 8, 1954, and she remained married to him until his death. (DX 24, DX 21). The Miner had one dependent for purposes of augmentation of benefits, namely his wife. Claimant has no dependents. (DX 3, 21). Claimant and her son testified at the hearing held herein. According to Claimant, her husband had difficulties breathing and he had problems walking. (Tr. 20). He also had problems sleeping, coughed and produced brown sputum. (Tr. 20-21). Prior to his death, he was on continuous oxygen. (Tr. 22). The Miner's work history included employment at a cotton mill, at Allied Steel and in coal mines. (Tr. 24-25). At one point, the Miner filed a lawsuit regarding his exposure to asbestos. (Tr. 26). He suffered from cancer of the esophagus. (Tr. 29). He was a smoker when Claimant met him in 1953. (Tr. 30). He had not smoked in about twenty years at the time of his death. (Tr. 30). He quit smoking in the late 1980's. (Tr. 31). The Miner's son testified that his father was constantly congested and had great difficulty breathing. (tr. 35). He was on oxygen a good year and a half before his death. (Tr. 36).

Length of Coal Mine Employment

Employer has stipulated to 14.5 years of coal mine employment. (Tr. 17). This stipulation is supported by the documented evidence of record. (DX 6, 23). Accordingly, I find that Presley Morrow was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations for at least 14.5 years. He last worked as a coal miner in 1991.

Responsible Operator

Drummond Company, Inc. does not contest that it was properly designated the responsible operator herein. (DX 44, 45). Accordingly, I find that Drummond Company, Inc. is the responsible operator in this case.

Applicable Law

Because this claim was filed after the enactment of the Part 718 regulations, entitlement to benefits will be evaluated under the Part 718 standards. 20 C.F.R. § 718.2. In order to establish entitlement to benefits in the Miner's claim, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) that the Miner suffered from pneumoconiosis, (2) the pneumoconiosis arose out of CME, (3) the Miner was totally disabled, and (4) his total disability was caused by pneumoconiosis. *See generally Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994); *see also 20 C.F.R. §§ 718.201 – 718.204.* With respect to the survivor's claim, Claimant must establish by a preponderance of the evidence, that the Miner's death was due to pneumoconiosis. Evidence which is in equipoise is insufficient to sustain a claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, supra.* Failure to establish any one of these elements precludes entitlement to benefits.

The 2001 amendments to the regulations significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. § 725.414(a)(2)(ii). Likewise, employers and the District Director are subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i, iii).

Modification of the Subsequent Miner's Claim

In cases where a claimant files more than one claim and the earlier claim is denied, the later claim must also be denied on the grounds of the earlier denial unless there has been a material change in condition or the later claim is a request for a modification. Thus, 20 C.F.R. § 725.309(d) provides that a subsequent claim must be denied unless the Claimant demonstrates

that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. The applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. § 725.309(d)(2). If the existence of one of these conditions is established, then, as a matter of law, a material change has been demonstrated. Then all of the record evidence must be reviewed to determine whether the Miner was entitled to benefits.

The Miner filed numerous claims, his most recent prior claim having been filed in 2000 and denied that same year. The Miner's current claim was filed in 2002, not within one year of the prior denial, so that it cannot be construed as a modification proceeding pursuant to Section 725.310(a). The 2002 claim was denied on January 22, 2003 and his widow's application, filed in May of 2003, was considered a request for modification of that denial, as well as a request for survivor's benefits. Those requests were denied on March 17, 2004, and Claimant filed another request for modification. Accordingly, this matter is before the undersigned on a request for modification of a duplicate claim.

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by 20 C.F.R. § 725.310, provide that upon a miner's own initiative, or upon the request of any party on the ground of a change in conditions or because of a mistake in a determination of fact, the fact-finder may, at any time prior to one year after the date of the last payment of benefits or any time before one year after the denial of a claim, reconsider the terms of an award of a denial of benefits. § 725.310(a).

In January of 2003, the Miner's duplicate claim was denied on the basis that the evidence failed to show the existence of pneumoconiosis, that the disease was caused at least in part by coal mine work, and that the Miner was totally disabled by the disease. In the Proposed Decision and Order Denying Request for Modification issued on March 17, 2004, it was determined that while the Miner had established a material change in condition, inasmuch as the existence of coal worker's pneumoconiosis had been established, benefits should be denied because the Miner had failed to establish total disability due thereto. A request for modification of this denial was then filed.

The record in the Miner's claim will be evaluated under Section 725.310. In evaluating a request for modification under Section 725.310, it is not enough that the administrative law judge conduct a substantial evidence review of the district director's finding. Rather, the claimant is entitled to *de novo* consideration of the issue. *Kovac v. BCNR Mining Corp*., 14 B.L.R. 1-156 (1990), *aff'd on recon.,* 16 B.L.R. 1-71 (1992); *Dingess v. Director, OWCP*, 12 B.L.R. 1-141 (1989); *Cooper v. Director, OWCP*, 11 B.L.R. 1-95 (1988). *See also* 20 C.F.R. § 725.310(c). Neither the original claim nor the subsequent claim has been adjudicated by an administrative law judge. Thus, my review of the record is *de novo* in order to determine if the Miner was entitled to benefits under the Act.

Medical Evidence

X-ray Readings

While prior claims contained x-ray readings, there are no readings rendered and submitted with the duplicate claim for benefits wherein pneumoconiosis is classified. Chest x-rays taken during the Miner's medical treatment at Walker Baptist Medical Center are in the record. (CX 5). They were not read for the purpose of classifying pneumoconiosis. Some were found to be indicative of chronic obstructive pulmonary disease. A chest x-ray from June 3, 2002 was read by Dr. Sanders as revealing severe chronic lung disease with interstitial fibrosis as well as extensive pleural scarring. On September 11, 2001, a chest x-ray was taken and read by Dr. Hager as indicative of COPD and chronic interstitial lung disease. (DX 12).

Pulmonary Function Studies

The record contains the results of one pulmonary function study conducted by Dr. Westerman on October 11, 2001. (DX 12). It listed the Miner's height as 69", his age as 72 years and produced an FEV1 of 1.94 and an FVC of 3.36. (DX 12). The study failed to produce values indicative of total disability.

Blood Gas Studies

A blood gas study conducted on June 3, 2002 produced a PC02 of 31.8 and a P02 of 63, which are qualifying values. (DX 11). Several studies were conducted while the Miner was hospitalized during his final hospitalization. (CX 5). The regulations at 20 C.F.R. § 718.105(d) provide that where one or more blood gas studies producing results which meet the appropriate table in Appendix C were administrated during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report prevents reliance on those studies as evidence of total disability. No such report has been produced and therefore, these blood gas studies do no assist in the disability determination to be made herein.

Medical Reports

Dr. Jan Westerman

Dr. Jan Westerman indicated that the Miner was seen on June 19, 2002 at the Pulmonary and Sleep Associates of Jasper. (DX 27). Dr. Westerman found the Miner to be suffering from severe COPD, chronic respiratory insufficiency, ventricular dysrhythmia, hypothyroidism, history of prior ruptured esophagus, probable some degree of pneumoconiosis. In his opinion, the Miner was extremely debilitated. Dr. Westerman stated that the Miner's degree of respiratory disease precluded him from coal mine work. He further noted that the Miner was a smoker and that he had end-stage lung disease. Dr. Westerman is board-certified in internal medicine and pulmonary diseases.

Dr. J. B. Weaver

Dr. J. B. Weaver submitted reports dated April 25, 2002 and June 18, 2002. (DX 8, 9, CX 4). In the April 25, 2002 report, which consisted of two sentences, Dr. Weaver stated that the Miner was completely disabled and had a component of black lung. In the June letter, he stated that he was the physician who treats the Miner for pneumoconiosis and COPD. It was his opinion that the Miner had severe end-stage lung disease. Dr. Weaver opined that the Miner had severe chronic lung disease with interstitial fibrosis with extensive pleural scarring, which was consistent with black lung disease secondary to coal mine dust inhalation. Dr. Weaver noted that the Miner had a smoking history which also contributed to this problem, but coal mine dust exposure was the greatest cause of his current pulmonary disease. In his opinion, the disease was such that the Miner could not work in any job, let alone coal mining.

Treatment Records

Records from AMI Brookwood Medical Center have been submitted. (DX 32). The Miner was hospitalized on June 24, 1989 and discharged on September 18, 1989. The final diagnosis included (1) severe ulcerative esophagitis with sclerosis, Barretts esophagus; (2) chronic gastritis; (3) respiratory failure; (4) hyponatremia; (5) hypokalemia; 6) atrial fem flutter; (7) pneumonia; (8) chronic obstructive pulmonary disease; and (9) alcohol withdrawal. A social history included that the Miner smoked two packs of cigarettes per day, having done so for fifty years. The attending physician was Dr. J. Thomas Williams, Jr.

Medical Records from Walker Baptist Medical Center dating from November 14, 2002 to November 23, 2002 have been submitted. (CX 5). Those pages which are handwritten are, for the most part, illegible. That hospitalization ended with the Miner's death. The Discharge Diagnosis from Dr. Swapan K. Chaudhuri included (1) left lower lobe pneumonia; (2) respiratory failure; (3) acute on chronic obstructive pulmonary disease; (4) congestive heart failure; (5) leukocytosis; and (6) hypothyroidism. The Miner's past medical history was listed as significant for COPD, cancer of the esophagus, arthritis, abdominal hernia, and oxygen dependence at home. In a Consultation, Dr. Jan Westerman noted that the Miner was in acute and chronic respiratory failure, with evidence of community-acquired pneumonia and severe chronic obstructive pulmonary disease. Dr. Westerman classified the Miner's condition as an end-stage chronic obstructive pulmonary disease. During arterial blood gas testing, it was noted that the Miner's carboxyhemoglobin was at 2.0 and 2.1, with the range of 1.5-5.0 being indicative of smokers.

Death Certificate

The death certificate, signed by Dr. Eagle Chen, lists the cause of death as pneumonia due to COPD. (DX 26). The date of death was November 23, 2002.

Dr. Mary-Louise Guerry Force

Dr. Mary-Louise Guerry Force performed an autopsy on November 23, 2002. (DX 29). The autopsy was limited to the lungs and the Final Anatomic Diagnosis included (1) acute

bronchopneumonia, multifocal; (2) coccal bacterial forms identified on routine stains; (3) pulmonary thromboemboli, right lower lobe; (4) severe centrilobular emphysema; (5) silicosiderosis; and (6) focal fibrovascular visceral pleural adhesions. Her gross description of the lungs included findings of black pigmented macules from 0.2 to 0.4 cm in diameter. Microscopic examination revealed that the pigmented areas of the lung described grossly, microscopically were predominantly areas of iron-containing tissue. The predominant pigment seen was iron. She found silicosiderosis to be present, which was a form of mixed dust fibrosis. She concluded as follows:

> This condition has been associated with a variety of occupational exposures where there is exposure to iron and silicate/quartz containing materials, including but not limited to, certain forms of mining, certain types of foundry and steel mill work and certain types of welding.

Dr. Guerry Force is board certified in anatomic and clinical pathology.

Dr. David Gaziano

By report dated March 14, 2005, Dr. David Gaziano stated that he had reviewed the medical records provided to him by counsel for Claimant. (CX 2, 4). Dr. Gaziano found that it was clear, based on the x-ray interpretations and autopsy report, that the Miner had occupational pneumoconiosis. In his opinion, it was contracted primarily from his underground coal mining experience. He also found emphysema undoubtedly related to his cigarette smoking. The Miner had advanced end-stage lung disease and his death was a respiratory death with associated pneumonia. It was his opinion, to a reasonable degree of medical certainty, that both the Miner's occupational pneumoconiosis and his chronic obstructive pulmonary disease were significant contributory factors in death. Thus, it was his conclusion that the Miner met the requirements of a finding that death was caused by or contributed to by occupational pneumoconiosis.

In a letter dated October 20, 2005, Dr. Gaziano stated that he had reviewed medical records from Walker Baptist Medical Center dating from November 14, 2002 through November 23, 2002. (CX 6). That review confirmed his previous impression that the Miner had end-stage advanced chronic lung disease prior to developing a community acquired pneumonia. Dr. Gaziano opined that the Miner had occupational pneumoconiosis and stated that the records reaffirmed his opinion as stated in his March 14, 2005 report.

By letter dated November 10, 2005 Dr. Gaziano stated that he had reviewed Dr. Russakoff's letter of September 2, 2005. (CX 7). Dr. Gaziano noted that he did, in fact, as claimed by Dr. Russakoff, take certain portions of the medical records at face value. He pointed out that the autopsy findings of the presence of occupational pneumoconiosis would support the x-ray findings of pneumoconiosis. Even if the x-ray readings were negative, it was his opinion that the pathology findings would represent the final decision on that issue. According to Dr. Gaziano, it was not necessary to assess the pulmonary function values if the patient was confined and requiring oxygen on a continuous basis, as this, in and of itself, represented a far-advanced

lung condition. Dr. Gaziano found that the blood gas testing on June 15, 2000 showed a moderate decrease in arterial oxygen tension at rest, which would support the findings of an obstructive and restrictive ventilatory impairment. Taking all of the information together, it was his opinion that it was easy to make a diagnosis of an occupational pneumoconiosis and chronic obstructive pulmonary disease of an end-stage type with respiratory failure, with the final event being that of a community acquired pneumonia resulting in death. Dr. Gaziano concluded that his opinion remained as stated in his letter of March 14, 2005. Dr. Gaziano is board-certified in internal medicine, chest diseases and critical care medicine.

Dr. A. David Russakoff

Dr. A. David Russakoff submitted a report dated January 31, 2005, after reviewing medical evidence including the autopsy report, and death certificate. (EX 1). Dr. Russakoff is board-certified in internal medicine and pulmonary diseases. He noted that Dr. Hasson's report from 1984 revealed a cigarette smoking history of significance, averaging two packs per day for 34 years, the Miner still smoking at the time of his 1984 exam by Dr. Hasson. Dr. Russakoff noted that he was discounting the May 4, 2000 report of Dr. George Weaver, as, while Dr. Weaver stated there were chest films showing fibrotic interstitial lung disease, no supporting documentation was provided and the evidence he reviewed did not support such a statement. He found support for the need for continuous oxygen administration at home from the sleep study results obtained by Dr. Westerman in 2001. Comparing pulmonary function testing conducted in 1984 by Dr. Hasson with that conducted by Dr. Westerman in 2001, Dr. Russakoff found no significant deterioration in values, negating a finding that there was any permanent lung disease in process. Dr. Russakoff noted that there were no hospital records available to review, regarding the Miner's final hospitalization. Based upon his review, Dr. Russakoff pointed out that the Miner was primarily a welder who spent the majority of his welding years in the steel industry and a lesser amount of time working as a welder in the coal mining industry. The Miner was also a significant cigarette smoker with an extensive pack/year history. Complicating his course was the fact that in 1989 he was diagnosed with Barretts esophagus and had surgery wherein a good portion of his esophagus was removed and his stomach was repositioned up into his chest and connected to his upper esophagus to allow normal swallowing. Complicating this procedure was the development of strictures at the anastomotic site that required repeated dilations. This situation resulted in lung infections and subsequent impairments. After the 1989 surgery, any lung exam was going to be abnormal as a result of the post-surgical changes from the surgery, such as scarring and deformities. Dr. Russakoff stated that he was discounting the reports of both Drs. J.B. and George Weaver because, while good family practitioners, they were not experts in occupational lung disease issues and their reports and records did not contain any information which would support their contentions.

Upon reviewing the autopsy report of Dr. Guerry Force, Dr. Russakoff noted that she made no mention of any coal macules manifest by coal dust accumulation associated with a fibrotic reaction that are the pathological microscopic requirements for the diagnosis of coal worker's pneumoconiosis. There was also no description of any changes of progressive massive fibrosis. She did describe the presence of iron containing pigment which makes the diagnosis of siderosis. It was his opinion that the combination of pneumonia and pulmonary emboli plus

emphysema was the likely cause of death. Dr. Russakoff found nothing in the evidence that would implicate any role for coal dust in the Miner's death.

Based upon his review of the evidence, Dr. Russakoff concluded that the Miner did not suffer from coal worker's pneumoconiosis or any other disease related to coal dust exposure. Death was not caused by or contributed to or hastened by coal worker's pneumoconiosis. According to Dr. Russakoff, while siderosis is considered a pneumoconiosis (dust disease of the lung) because it is caused by the inhalation of iron containing dust, it generally does not cause impairment in the lung function or disability.

In a Supplemental Report dated September 2, 2005, Dr. Russakoff stated that he had reviewed his own report set forth above, as well as the reports of Drs. Caffrey and Gaziano. (EX 3). Based upon that review, Dr. Russakoff stated that while Dr. Gaziano reviewed the medical evidence and concluded that the Miner suffered from coal worker's pneumoconiosis and that the disease was contributory to the Miner's demise, it appeared to Dr. Russakoff that Dr. Gaziano took all the various opinions and diagnoses in the record at face value and did not attempt to discuss the inconsistencies between the reported pulmonary function values and the arterial blood gas studies. He also did not review the tracings to make a judgment nor did he review the autopsy slides, relying instead on the report of Dr. Geurry-Force. Dr. Russakoff did not find this to be a critical analysis of the data. Relying upon his own report and the report of Dr. Caffrey, Dr. Russakoff found no evidence to support a diagnosis of coal worker's pneumoconiosis and no evidence that the disease was in any way related to the Miner's demise.

Dr. P. Raphael Caffrey

Dr. P. Raphael Caffrey submitted a report dated February 24, 2005, after reviewing medical evidence including autopsy slides. (EX 2). Dr. Caffrey is board-certified in anatomical and clinical pathology. Based upon his review of the slides, Dr. Caffrey found (1) acute bronchopneumonia, diffuse; (2) pulmonary siderosis; (3) mild amount of anthracotic pigment (coal dust); (4) centrilobular emphysema, moderate to severe; and (5) few thromboemboli without infarction. Dr. Caffrey noted that the records established 14.5 years of underground coal mine employment and 14 years at a steel company. The smoking history was that of 41 years at the rate of two packs of cigarettes per day from Dr. Goldstein, and two packs per day for fifty years from AMI Brookwood Medical Center. Dr. Caffrey's review of the medical evidence noted that the hospital records from the November 2002 admission were not available. He did, however, review the death certificate. Based upon his review, Dr. Caffrey concluded that he was unable to make a diagnosis of coal worker's pneumoconiosis. The autopsy slides showed the presence of anthracitic pigment but that was not synonymous with the disease of coal worker's pneumoconiosis. Dr. Caffrey concluded that the majority of the pigment he saw was hemosiderin or iron pigment related to the miner's employment as a welder. The Miner's severe COPD was due to his 40-50 years of smoking two packs of cigarettes per day. Death was not caused by, contributed to or hastened by pneumoconiosis.

Dr. Caffrey stated that he had reviewed the autopsy report of Dr. Guerry Force and noted she found silicosiderosis and concluded that it has been associated with a variety of occupational exposures where there is exposure to iron and silicate/quartz containing materials, including but

not limited to, certain forms of mining, certain types of foundry and steel mill work and certain types of welding. While she said the changes described as silicosiderosis were a form of mixed dust fibrosis, Dr. Caffrey stated that he found no nodules microscopically which would be considered nodules of silicosis or nodules of mixed dust fibrosis. He found the difference between his diagnosis of pulmonary siderosis and that of Dr. Guerry Force of silicosiderosis to be minimal because the miner's pulmonary problems were not due to the inhalation of iron and/or coal dust but primarily due to his cigarette smoking history with severe COPD. The fact that the Miner was employed as a welder for many years in the steel and coal mining industries did not cause him any significant pulmonary disability and certainly did not cause, contribute to or hasten death. Dr. Caffrey concluded that the Miner did not suffer any significant pulmonary disability as a result of his work as a coal miner. He did suffer from emphysema, chronic bronchitis and COPD, all of which were the result of years of smoking. Death was due to pneumonia.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal" pneumoconiosis.

(1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201.

20 C.F.R. § 718.202(a), provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), § 718.305 (not applicable to claims filed after January 1, 1982) or § 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no x-ray evidence of pneumoconiosis submitted with the duplicate claim. Those x-rays which were submitted do not diagnose pneumoconiosis. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis and the Miner filed his claim after January 1, 1982, and he died after March 1, 1978. There is no relevant biopsy evidence of record. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the autopsy evidence and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that the Miner had pneumoconiosis. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

In his post-hearing brief, counsel for Employer has conceded a change in condition, inasmuch as Dr. Russakoff acknowledged that the autopsy report contained the requisite findings for a diagnosis of clinical pneumoconiosis, further conceding, pursuant to 20 C.F.R. § 718.203, that that pneumoconiosis arose out of coal mine employment. The issue in the Miner's claim, therefore is whether the evidence establishes total disability due to the disease. As a change in condition has been established all the evidence must be reviewed in the Miner's claim. Therefore, the pertinent evidence submitted with his prior claims will now be discussed. Not detailed, although reviewed, given that the issue of pneumoconiosis has been conceded, is the x-ray evidence.

Total Disability

A miner is considered to have been totally disabled if he had complicated pneumoconiosis, 30 U.S.C. §§ 921(c)(3), 20 C.F.R. § 718.304, or if he had a pulmonary or respiratory impairment to which pneumoconiosis was a substantially contributing cause, and which prevented him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the

miner's statements or testimony. 20 C.F.R. § 718.204(d) ; *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Miner suffered from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

Pulmonary Function Studies

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where a pulmonary function tests demonstrate FEV1 values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC or MVV values equal to or less than the applicable table values. Alternatively, a qualifying FEV1 reading together with an FEV1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2)(i) and Appendix B. Assessments of these results is dependent on the Claimant's height which was recorded as 68, 68.5, 69, 69.5 and 71 inches. Considering this discrepancy, I find the Claimant's height to be 69.2 inches for the purposes of evaluating the pulmonary function studies. *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983).

In the instant case, the one pulmonary function study conducted since the prior denial produced non-qualifying values. The record also contains pulmonary function studies conducted in 1984, 1991, 1996 and 2000. (DX 1). Dr. Hasson performed a study in 1984 and noted that the Miner's cooperation and effort were poor. The values obtained (FEV1 – 2.03, FVC – 3.87 and MVV – 45) are qualifying for a miner whose age is 54 years and whose height is 69.2". I do not find that study to be persuasive, however, given the Miner's poor effort and the fact that it was performed so long ago, making it not a reliable indicator of the Miner's pulmonary function in 2002. A study conducted on July 2, 1991 produced an FEV1 of 1.56, an FVC of 3.75 and an MVV of 53.70. (DX 1). The Miner's effort and cooperation were listed as good. The study conducted on August 15, 1991 produced an FEV 1 of 1.37, an FVC of 3.26 and an MVV of 29.43, the Miner's effort and cooperation being listed as fair. (DX 1). Dr. Kraman found the two studies conducted in 1991 to be invalid due to less than optimal effort, cooperation and comprehension.

The study conducted on February 1, 1996 failed to produce values indicative of total disability, producing an FEV1 of 2.09, an FVC of 3.87 and an MVV of 66. (DX 1). The study conducted on June 15, 2000 produced an FEV1 of 1.48, an FVC of 2.52 and an MVV of 49. (DX 1). The Miner's effort was listed as good "for this patient." It produced values indicative of total disability. The study was found to be valid by Dr. Michos.

Given that pneumoconiosis is a progressive disease and the results are effort dependent, I find the most recent study, conducted in 2001 by Dr. Westerman, to be the most probative. Accordingly, based on the most recent, non-qualifying study, I find that total disability has not been established pursuant to 20 C.F.R. § 718.204(b)(2)(i).

Arterial Blood Gas Studies

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO2 to pO2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the Claimant's lung alveoli to his blood. § 718.204(b)(2)(ii) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations.

A blood gas study conducted in 1984 by Dr. Hasson failed to produce values indicative of total disability. (DX 1). The blood gas studies conducted by Dr. Goldstein in July of 1991 and February of 1996 also failed to produce values indicative of total disability. A study conducted on June 15, 2000, by Dr. Hasson, produced values indicative of total disability. (DX 1). The study was found to be valid by Dr. Michos. (DX 1). On June 3, 2002, while the Miner was hospitalized, a blood gas study was conducted which produced values indicative of total disability.[3] (DX 11). The record also contains several blood gas studies taken during the Miner's final hospitalization. (CX 5). I find that the studies conducted during the Miner's final hospitalization are not probative on this issue. (See supra.) Based on the qualifying study of June of 2000, however, I find that total disability has been established pursuant to 20 CFR § 718.204(b)(2)(ii).

Medical Opinion Evidence

Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(iii), Section 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work. The medical opinion evidence submitted with the prior claims will be reviewed prior to discussing all the medical opinion evidence of record.

Dr. Jack Hasson

Dr. Jack Hasson examined Claimant in May of 1984. (DX 1). He recorded a smoking history of two packs per day for thirty-four years and found the Miner to be suffering from mild pneumoconiosis, radiographic and chronic bronchitis. No assessment was made regarding disability. On June 15, 2000, Dr. Hasson examined the Miner again. (DX 1). Fifteen and a half years of coal mine employment was noted, as was a cigarette smoking history of one pack per day from 1951 to 1985. Dr. Hasson found no evidence of pneumoconiosis and diagnosed COPD due to cigarette smoking. He found the impairment to be moderate. Dr. Hasson is board-certified in internal medicine, critical care medicine and pulmonary diseases.

[3] During that study, the Miner's carboxyhemoglobin level was found to be 3.1, indicative of a heavy smoker. (DX 11).

Dr. Allan R. Goldstein

Dr. Allan R. Goldstein examined the Miner On July 2, 1991. (DX 1). He recorded a smoking history starting at the age of eighteen years and continuing until 1988, the Miner having consumed two packs of cigarettes per day. Dr. Goldstein diagnosed COPD due to smoking and atrial arrhythmia, which he believed might be due to coronary artery disease. Dr. Goldstein found a 100% impairment secondary to both diagnosed conditions, with 90% of that disability being due to the COPD. Dr. Goldstein examined the Miner again in February of 1996. At that time, he recorded a smoking history of one pack of cigarettes per day from 1950 to 1990. Dr. Goldstein found the Miner to be suffering from COPD and hemoptysis, finding the former to be due to cigarette smoking. He found the Miner's impairment to be moderate to severe, and due 100% to his chronic obstructive pulmonary disease. Dr. Goldstein is board-certified in internal medicine and pulmonary diseases.

Dr. George H. Weaver

By report dated February 22, 1992, Dr. George H. Weaver indicated that the Miner was totally disabled due to injuries suffered to his left leg. (DX 1). On May 2000, Dr. Weaver indicated that the Miner worked in the coal mines for eighteen years as a welder, that chest x-rays showed fibrotic interstitial lung disease and he felt that this was due to occupational exposure to welding dust in underground coal mines. (DX 28).

Treatment Records

Treatment records from 1988 through 1991 have been submitted. (DX 1). Those pages which are handwritten are illegible. In 1988, the Miner was hospitalized, the Final Diagnosis by Dr. Weaver being (1) tachycardia; (2) hypotension; (3) history of active ulcer disease; (4) history of hiatal hernia; (5) chronic interstitial lung disease; and (6) status post appendectomy. A medical record regarding treatment of cancer of the esophagus mentions a smoking history of two packs of cigarettes for fifty years. (DX 1). A record from August 2, 1989 lists an Impression of chronic obstructive pulmonary disease secondary to tobacco abuse and coal dust exposure. (DX 1).

A CT scan taken on September 28, 1999 was read by Dr. Stephen Sanders as showing post surgical changes of the esophagus, COPD with bronchitis and a 1.5 cm subcarinal node with smaller pretracheal nodes.

Dr. J. Thomas Williams noted that the Miner was seen for his status post esophagogastrectomy. (DX 1). Records regarding his treatment dealing with his esophago-gastrectomy are in the record. They make no mention of coal worker's pneumoconiosis. In 1991, the Miner was hospitalized after presenting with the chief complaint of rapid heart beat. The Final Diagnosis by Dr. George Weaver was (1) cardiac arrhythmia; (2) bigeminy; (3) COPD; (4) status post resection of carcinoma of the esophagus; and (5) esophageal stricture.

In this case, every physician finds the Miner to have been totally disabled by a respiratory disease prior to death. Dr. Westerman found an end-stage lung disease, finding severe COPD

and chronic respiratory insufficiency. Dr. Guerry Force found, on autopsy, that there was severe centrilobular emphysema to be present as well as silicosiderosis. Dr. J.B. Weaver found severe chronic lung disease, while Dr. Gaziano found advanced end-stage lung disease. Dr. Russakoff also concluded that the Miner suffered from respiratory conditions, one of which, emphysema was a factor in death. Dr. Caffrey diagnosed COPD, bronchitis and emphysema. Dr. George Weaver also found a lung disease to be present.

It is obvious that the Miner suffered from pulmonary disease which was disabling prior to his death. Accordingly, I find that total disability has been established pursuant to 20 C.F.R. § 718.204(b)(2)(iv). Weighing the contrary medical opinion evidence of record, I find it insufficient to outweigh the medical opinion and blood gas study evidence, which establishes a totally disabling respiratory disease.

Causation of Total Disability

In order to establish the Miner's entitlement to benefits, Claimant needs to establish that pneumoconiosis was a "substantially contributing cause" to the Miner's disability. A "substantially contributing cause" is one which has a material adverse effect on the Miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 C.F.R. § 718.204(c).

The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Upon reviewing the medical opinion evidence, I find it insufficient to meet Claimant's burden of proof, that the Miner's pulmonary disability was the result of coal mine dust inhalation. Thus, it is apparent that the Miner had an extensive smoking history as well as other respiratory conditions which were unrelated to coal mine dust inhalation and which caused a pulmonary disability. In this respect, I find the medical opinion of Dr. Russakoff most thoroughly reviews the Miner's medical conditions and provides the most persuasive discussion of the etiology of the disability suffered by him. I further find, for purposes of assessing the medical reports, that the Miner had a smoking history of at least fifty years at the rate of up to two packs of cigarettes per day. In so concluding, I find the reports the Miner first gave to Dr. Hasson, as well as that given in the hospital, to be the most reliable indicators of his smoking history.

In relying upon the medical opinion of Dr. Russakoff, I note that it is also supported by several other physicians. Thus, while, in 1984, Dr. Hasson found a condition related to coal mine dust inhalation, in 1996 he found the disease to be absent. Dr. Westerman finds it "probable" that some degree of pneumoconiosis is present, an opinion which, at best is equivocal, and significantly, proceeds to find an end-stage lung disease, without specifically attributing same to his coal mine dust inhalation. Dr. Goldstein fails to find coal worker's pneumoconiosis and attributes the Miner's pulmonary disability to his extensive smoking history. As was the case with Dr. Hasson, Dr. Goldstein finds a significant smoking history and COPD due to smoking. The treatment records also point to the Claimant's significant smoking history. The death certificate does not assist in a determination of the etiology of the Miner's COPD. Dr. Guerry Force finds silicosiderosis, but makes no assessment regarding the etiology

of the Miner's pulmonary disability or the impact of the silcosiderosis on the Miner's pulmonary condition.

Dr. J. B. Weaver finds the Miner to have severe chronic lung disease consistent with black lung disease, however, he fails to provide any basis for his conclusion. I find that he fails to adequately explain how he can conclude that the Miner's disability is due to coal mine dust exposure as opposed to the other conditions suffered by the Miner or his extensive smoking history. Similarly, Dr. George Weaver makes broad statements without adequate rationale or support. I do not find their opinions well-reasoned or well-documented. As noted, the treatment records also are insufficient to affirmatively establish coal mine dust inhalation as the etiology of the Miner's disabling respiratory impairment and indeed, lead to the conclusion that the Miner was not being treated for coal worker's pneumoconiosis. Finally, I do not find the medical opinion of Dr. Gaziano to be as persuasive or well-reasoned as that of Dr. Russakoff. While Dr. Gaziano finds that the Miner had occupational pneumoconiosis, he does not adequately explain how he can attribute the Miner's end-stage lung disease to coal mine dust inhalation as opposed to his other conditions and in particular the Miner's extensive smoking history. He also fails to adequately address the issue of the findings on autopsy which found the predominant pigment to be iron. Dr. Gaziano and the Drs. Weaver render opinions which are lacking in support and documentation and which fail to fully address all the issues relevant to the Miner's pulmonary condition. This renders their opinions less persuasive.

Based in particular upon the medical opinions of Drs. Russakoff and Caffrey, I find that the Miner's disabling pulmonary impairment was not due to coal mine dust exposure, but to cigarette smoking. Indeed, both Drs. Caffrey and Russakoff specifically pointed out that the Miner's siderosis was not disabling. Thus, even assuming, arguendo, that the Miner's siderosis was due to coal mine dust exposure, the reports of these physicians establish that that condition was not disabling. Thus, I find that Claimant is unable to meet her burden of establishing that the Miner was totally disabled due to coal worker's pneumoconiosis, and that same has not been established pursuant to 20 C.F.R. § 718.204(c). Accordingly, the Miner was not entitled to benefits during his lifetime.

Claimant has failed to meet her burden to establish that the Miner was totally disabled by coal mine dust inhalation. Therefore, the Miner's claim for benefits must be denied. Next to be considered is the survivor's claim.

Death Due to Pneumoconiosis [4]

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that the miner's death was due to pneumoconiosis;

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or where death was caused by complications of pneumoconiosis; or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205(c).

Pneumoconiosis is a substantially contributing cause of a miner's death if it hastens the miner's death. 20 C.F.R. § 718.205(c)(5). The circuit courts developed the "hastening death" standard, which has been incorporated into the amendments to the regulations. This standard requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death.

The death certificate makes no mention of the disease as a factor in death. Dr. Guerry Force does not list it as a cause of death in her autopsy report. Drs. Caffrey and Russakoff specifically find it played no role in death. Dr. Gaziano is the only physician to affirmatively find it was a factor in the Miner's death. I find his opinion, for the reasons set forth above, to be outweighed by the contrary medical opinion evidence of record. In particular, I find the reports of Drs. Russakoff and Caffrey to be the more persuasive on this issue. I would note that Dr. Caffrey is a board-certified pathologist who had an opportunity to review the autopsy slides. Dr. Gaziano did not.

In sum, I find the report of Dr. Gaziano to be outweighed by those of Drs. Caffrey and Russakoff. The hospitalization records also do not establish that coal mine dust inhalation was a contributor to death. Accordingly, having reviewed all of the medical evidence of record, I find the opinions of Drs. Russakoff and Caffrey to be the most persuasive and worthy of the greatest weight. In according greater weight to their opinions, I rely upon their expertise as well as the reasoning rendered in their reports, finding same to be more persuasive than the contrary opinion evidence of record.

[4] It is noted that, because the survivor's claim was filed after the effect date of the amended regulations, which limited the submission of evidence, some medical opinions in the survivor's claim are impermissibly based, in part, on evidence continued in the previously filed Miner's claim. However, the opinions remain probative with regard to the cause of death because the physicians also relied on properly admitted autopsy evidence as well as hospitalization records generated at the time of the miner's death.

Based upon the totality of the evidence of record, I find that Claimant has failed to meet her burden of proving that coal worker's pneumoconiosis contributed to the Miner's death pursuant to 20 C.F.R. § 718.205(c). While it is apparent that the Miner suffered from a totally disabling respiratory impairment prior to death and that his was a pulmonary death, there is no competent evidence establishing the link between his coal mine employment and death.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claims of Presley Morrow and Terra Morrow for benefits under the Act are DENIED.

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RALPH A. ROMANO
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).